

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/13/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151328		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 08/17/2011	
NAME OF PROVIDER OR SUPPLIER BEDFORD REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2900 W 16TH ST BEDFORD, IN47421			
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S0000	This visit was for a State licensure survey. Facility Number: 004683 Dates: 8-16-11 through 8-17-11 Surveyors: Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor Ken Zeigler Laboratory Surveyor Deborah Franco, RN Public Health Nurse Surveyor QA: claughlin 09/19/11			S0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0318	<p>410 IAC 15-1.4-1(c)(6)(F)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care.</p> <p>Based on document review and interview, the governing board failed to ensure cardiopulmonary resuscitation (CPR) competence for 1 of 1 physician anesthesiologist as required by the medical staff rules and regulations.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the credential file on 8-16-11 for MD#2, who was appointed 2-28-11, lacked evidence the physician had documentation of current ACLS certification. 2. Review of the medical staff rules and regulations on 8-16-11 indicated the following: All physicians and allied health professionals who practice in high risk areas (defined as emergency room, internists on call for the hospital, anesthesia, and intensive care) are 			S0318	<p>Plan of Correction: 1. Physician notified 8-23-2011 of noncompliance Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Physician Involved Education Coordinator – Tony Holt Completion Date: Recertified in ACLS September 7, 2011 2. Review Medical Staff Rules and Regulations regarding "All physicians and allied health professional who practice in high risk areas (defined as emergency room, internists on-call for the hospital, anesthesia, and intensive care) are required to be ACLS competent. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS CEO Administrative Assistant – Karen Ellis Completion Date: Review to be completed by November 4, 2011 3. Review, revise/or</p>		12/04/2011

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	required to be ACLS competent. ACLS competency will need to be renewed every two years and will be monitored at re-appointment time. 3. Interview with #S2 on 8-17-11 at 1430 hours confirmed MD#2 provides anesthesia and does not have current proof of ACLS certification.				develop policy or consistent process to ensure physician BLS, ACLS, and PALS certification remains current. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS CEO Administrative Assistant – Karen Ellis Education Coordinator – Tony Holt Completion Date: Review, revision or development of policy or process to be completed by November 4, 2011 4. Inservice/or Re-educate physicians, education staff, and administrative staff on the policy or process to ensure physician BLS, ACLS, and PALS certification remains current. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Education Coordinator – Tony Holt Completion Date: Education to be completed by December 4, 2011 5. Monitoring of compliance with Physician BLS, ACLS, and PALS Certification and recertification Will be sent to the Director of Quality monthly. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Education Coordinator – Tony Holt CEO Administrative Assistant – Karen Ellis Completion Date: Data to be abstracted and sent to Quality		

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S0556	<p>410 IAC 15-1.5-2(b)</p> <p>(b) There shall be an active, effective, and written hospital-wide infection control program. Included in this program shall be system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the facility failed to have an effective infection control program to prevent the spread of communicable diseases in patients and health care workers.</p> <p>Findings include:</p> <p>1. Review of personnel files on 8-16-11 lacked evidence that 22 of 23 staff members (P#1 - P#17, P#18, P#19, P#21 - P#23) had documented reliable proof of immunity to Varicella.</p> <p>2. Review of personnel files on 8-16-11 lacked evidence that 11 of 23 staff members (P#1, P#7, P#9 thru P#12, P#15, P#16, P#20, P#21, and P#23) had documented reliable proof of immunity to Rubeola.</p> <p>3. Review of personnel files on 8-16-11 lacked evidence that 5 of 23 staff members (P#1, P#10, P#14, P#21, and P#23) had documented reliable proof of</p>			S0556	<p>beginning with December 1, 2011 data</p> <p>Plan of Correction: 1.Review facility policy concerning the reliable proof of immunity to varicella, rubeola, and rubella.</p> <p>Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Occupational Health – Brian Brazzell Completion Date: Review to be completed by November 4, 20112. Revise/or develop policy concerning the reliable proof of immunity to varicella, rubeola, and rubella and develop a plan to bring existing employees into compliance. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Occupational Health – Brian Brazzell Completion Date: Revision or development of policy and the developme nt of a compliance plan to be completed by December 4, 20113. Inservice staff on the policy concerning the</p>		06/01/2012

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	immunity to Rubella. 4. Interviews with #S1 and #S2 on 8-16-11 at 1620 hours confirmed the findings for the above personnel and confirmed that these staff members do not have documented, reliable proof of immunity to Rubella, Rubeola or Varicella. 5. Interview with #S10 on 8-17-11 at 1500 hours confirmed the facility's infection control program does not ensure those without documented, reliable proof of immunity are prevented from working during a community outbreak of Rubella, Rubeola or Varicella in order to prevent the spread of communicable diseases to patients or other health care workers. 6. On 8/17/2011 at 2:45 PM, review of personnel files and interview with employee E #2 indicated: a. 7 employees (S#31, S#32, S#33, S#34, S#35, S#36, S#37) lacking reliable documentation of history of or immunity to Rubella. b. 7 employees (S#31-S#37) lacking reliable documentation of history of or immunity to Rubeola. c. 8 employees (S#31, S#32, S#33, S#35, S#36, S#37, S#38, S#40) lacking reliable documentation of history of or immunity to Varicella. d. 2 employees (S#2, S#5) lacking documentation of immunity to Hepatitis B or declination of vaccine offered by				reliable proof of immunity to varicella, rubeola, and rubella and the plan to bring existing employees into compliance Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Occupational Health – Brian Brazzell Education Coordinator – Tony Holt Completion Date: Education to be completed by January 3, 2012. Identify existing staff that are not compliant with reliable proof of immunity to varicella, rubeola, and rubella. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Occupational Health – Brian Brazzell Employee Health Nurse Completion Date: Identification to be completed by February 2, 2012 5. Phase I plan implementation to bring existing employees into compliance for reliable proof of immunity to varicella, rubeola, and rubella. Obtain lab draws on the first 50% of the identified facility employees Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Occupational Health – Brian Brazzell Employee Health Nurse Completion Date: Phase I lab draws to be completed by March 3, 2012. Phase II plan implementation to bring existing		

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	facility.				employees into compliance for reliable proof of immunity to varicella, rubeola, and rubella. Obtain lab draws on the second 50% of the identified facility employees Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Occupational Health – Brian Brazzell Employee Health Nurse Completion Date: Phase II lab draws to be completed by April 2, 20117. Phase III plan implementation to bring existing employees into compliance for reliable proof of immunity to varicella, rubeola, and rubella. Administer vaccinations to the first 50% of the identified facility employees. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Occupational Health – Brian Brazzell Employee Health Nurse Completion Date: Phase III vaccine administration to be completed by May 2, 20128. Phase IV plan implementation to bring existing employees into compliance for reliable proof of immunity to varicella, rubeola, and rubella. Administer vaccinations to the second 50% of the identified facility employees. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Occupational Health – Brian		

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					<p>Brazzell Employee Health Nurse Completion Date: Phase IV vaccine administration to be completed by June 1, 2012. Monitoring compliance of the facility policy concerning the reliable proof of immunity to varicella, rubeola, and rubella for new employees will be sent to the Director of Quality monthly X 3 then quarterly X 3. Responsible: Director of Quality & Compliance - Kathy Lewis, RN, MS Director of Occupational Health – Brian Brazzell Employee Health Nurse Completion Date: Data to be abstracted and sent to Quality beginning with October 1, 2011 data10. Monitoring of the facility plan to bring existing employees into compliance with reliable proof of immunity to varicella, rubeola, and rubella will be evaluated monthly until the completion of the plan Responsible: Director of Quality & Compliance - Kathy Lewis, RN, MS Director of Occupational Health – Brian Brazzell Employee Health Nurse Completion Date: Monthly evaluations to be completed by June 1, 2012</p>		

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S0596	<p>410 IAC 15-1.5-2(f)(3)(D)(iii)</p> <p>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based upon document review, observation, and interview the facility failed to ensure that biological indicators were used as provided in the Central Service Technical Manual to challenge the sterilization process in 2 of 2 steam autoclaves in the central supply area.</p>			S0596	<p>Plan of Correction: 1. Review of the Departmental Policies and Procedures concerning the challenge to the sterilization process for the 2 steam autoclaves in Central Supply</p> <p>Responsible: Central Supply Director, Sheila Doty, CMRP</p> <p>Completion Date: Review</p>		09/30/2011

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	<p>Findings included:</p> <p>1. Facility Central Service Technical Manual states that "Biological indicator process challenge should be used for routine sterilizer efficacy monitoring at least weekly (but preferably every day) that the sterilizer is used, and with every implant".</p> <p>2. During tour of the central service area on 8/17/2011 at 12 noon, and in the presence of E #1 and E #14, the biological log was reviewed and revealed biological indicator process challenges were performed only on loads with implantables.</p> <p>3. During interview on 8/17/2011 at 12:10 PM, Central Supply Manager E #14 stated that biological challenges are not run on a daily or weekly basis, but only prior to the sterilization of implantable devices.</p>				<p>completed September 15, 2011</p> <p>2. Revision of the Departmental Policies and Procedures concerning the challenge to the sterilization process for the 2 steam autoclaves in Central Supply Responsible: Central Supply Director, Sheila Doty, CMRP Completion Date: Revision completed September 19, 2011</p> <p>3. Inservice/or Re-educate Central Supply staff on the revision of the Departmental Policies and Procedures concerning the challenge to the sterilization process for the 2 steam autoclaves in Central Supply. Responsible: Central Supply Director, Sheila Doty, CMRP 3 M Infection Control Rep – Kelly Mitchum Completion Date: Education completed September 19, 2011</p> <p>4. Monitoring log implemented and biological indicator for validating the sterilization process has begun. Responsible: Central Supply Director, Sheila Doty, CMRP Completion Date: Implemented September 19, 2011</p> <p>5. Monitoring of compliance with validating the sterilization process will be sent to the Director of Quality Monthly X 3 and Quarterly X3. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Central Supply Director, Sheila Doty, CMRP Completion Date: Data to be abstracted and sent to</p>		

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S1118	<p>410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, document review, and interview, the facility created conditions which could result in hazards to patients, visitors, and staff in 1 of 1 maintenance department and 1 of 1 ambulance garage.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. While touring the facility on 8-17-11 at 1115 hours in the presence of #S3, seven (7) fire extinguishers were observed unsecured on the floor in the maintenance department. 2. While touring the facility on 8-17-11 at 1145 hours in the presence of #S3, an oxygen tank was observed unsecured on a desk in the ambulance garage. 3. Interview with #S3 on 8-17-11 at 1115 hours and 1145 hours respectively confirms the presence of 7 unsecured fire 			S1118	<p>quality beginning with October 1, 2011 data</p> <p>Plan of Correction: 1. The seven (7) fire extinguishers were removed from the Maintenance shop floor and stored appropriately Responsible: Director of Physical Plant – Phil Crulo Completion Date: August 17, 2011 The one (1) unsecured oxygen tank was removed from Ambulance garage desktop and secured in the O2 cabinet Responsible: Director of EMS – Bob Atkins Completion Date: August 17, 2011 2. Review Environment of Care policy concerning the storage of fire extinguishers and oxygen tanks Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Completion Date: Review to be completed by November 4, 2011 3. Revision of the Environment of Care policy concerning the safe storage of fire extinguishers and oxygen tanks Responsible: Director of Quality & Risk - Kathy Lewis,</p>		01/03/2012

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	extinguishers in the maintenance department and 1 unsecured oxygen tank in the ambulance garage which can result in a hazard to patients, visitors, and staff.				<p>RN, MS Completion Date: Revision to be completed by December 4, 2011 4. Inservice/or Re-educate staff on the policy concerning the safe storage of fire extinguishers and oxygen tanks Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Education Coordinator – Tony Holt Completion Date: Education to be completed by January 3, 2012 5. Monitoring of compliance with safe fire extinguisher and oxygen tank storage will be sent to the Director of Quality monthly X 3 then Quarterly X 3 Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Plant Operations – Phil Crulo Director of EMS – Bob Atkins Department Heads Completion Date: Date to be abstracted and sent to Quality beginning with January 1, 2012 data</p>		

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S1172	<p>410 IAC 15-1.5-8(e)(1)(A)(B)(C)</p> <p>(e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows:</p> <p>(1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(A) Asepsis (B) Cross-infection; and (C) Safe practice.</p> <p>Based on observation and interview, the hospital failed to ensure 2 of 2 anesthesiology pyxis machines were kept clean and orderly in accordance with current standards of practice.</p> <p>Findings included:</p> <p>1. On 8/17/2011, at 11:30 AM, on tour of the facility and in the presence of E #1 and E #12, the following was observed:</p> <p>a. Operating Room #2's anesthesiology pyxis machine's surfaces and sides were dusty. The working surface of the cart contained areas of a splattered dried white substance.</p> <p>b. The cart in OR #2 showed no evidence</p>			S1172	<p>Plan of Correction: 1. The two (2) pyxis machines in OR were cleaned. Responsible: Director of Anesthesia Completion Date: August 17, 2011 2. Review Anesthesia policy concerning the infection control responsibilities for Anesthesia. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Anesthesia Completion Date: Review to be completed by November 4, 2011 3. Revision of the Anesthesia policy concerning the infection control responsibilities for Anesthesia Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Anesthesia Completion Date: Revision to be completed by December 4, 2011 4. Inservice/or Re-educate</p>		01/03/2012

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	<p>of routine cleaning.</p> <p>c. Operating Room #4's anesthesiology pyxis machine's surfaces and sides were dusty. The working surface of the cart contained areas of a splattered dried white substance.</p> <p>d. The cart in OR #4 showed no evidence of routine cleaning.</p> <p>2. E #12 verified, during interview beginning at 2:30 PM on 8/17/2011, the following:</p> <p>a. Each operating room (2) contains a security controlled pyxis machine for use by the anesthesia department.</p> <p>b. The pyxis machines in these two (2) operating rooms were dusty, had a splattered dried white substance on the working surface and lacked evidence of routine cleaning.</p>				<p>staff on the Anesthesia policy concerning the infection control responsibilities for Anesthesia Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Anesthesia Completion Date: Education to be completed by January 3, 2012 5. Monitoring of compliance with infection control responsibilities of Anesthesia will be sent to the Director of Quality monthly X 3 then Quarterly X 3 Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Director of Anesthesia Completion Date: Data to be abstracted and sent to Quality beginning with January 1, 2012 data</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151328		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/17/2011	
NAME OF PROVIDER OR SUPPLIER BEDFORD REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2900 W 16TH ST BEDFORD, IN47421			
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S1186	<p>410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v)</p> <p>(f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.</p> <p>Based on document review and interview, the facility fire control plan failed to ensure night shift health care workers had appropriate training in the event of a fire.</p> <p>Findings include:</p> <p>1. Review of facility documents on 8-17-11 lacked evidence that the fire control plan ensured that the night shift staff received the same fire training as day shift staff; facility documents indicated fire drills were not conducted at the facility on the night shift for 4 of 4</p>			S1186	<p>Plan of Correction: 1. Silent Fire Drill held at 11:05 pm. Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Completion Date: September 29, 2011 2. Review Environment of Care policy concerning the facility fire plan and drills Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Completion Date: Review to be completed by November 4, 2011 3. Revision of the Environment of Care policy concerning the facility fire plan and drills Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Completion Date: Revision to</p>		01/03/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/13/2011

FORM APPROVED

OMB NO. 0938-0391

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	quarters (3rd and 4th quarters in 2010 and 1st and 2nd quarters in 2011) to ensure the competency of night shift staff. 2. Interviews with #S3 and #S12 on 8-17-11 at 1045 hours confirmed the facility has not ensured the fire safety competency of the night shift staff by conducting fire drills for the night shift, including any drills after 5:00 p.m., during the 3rd and 4th quarters in 2010 or the 1st and 2nd quarters in 2011.				be completed by December 4, 2011 4. Inservice/or Re-educate staff on the Environment of Care policy concerning the facility fire plan and drills Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Education Coordinator – Tony Holt Completion Date: Education to be completed by January 3, 2012 5. Monitoring of compliance with fire drill timing will be sent to the Director of Quality Quarterly Responsible: Director of Quality & Risk - Kathy Lewis, RN, MS Completion Date: Data to be abstracted and sent to Quality beginnin g with Qtr 4 2011 data		